CSA Reimbursement Rate Certification
Residential Treatment

Name of Child: _____

Medicaid Number: _____

Residential Treatment Provider:

_____

Address: _____
Street

_____,_____,_____
City State ZIP

Provider Number: _____

Community Policy and Management Team:

County/City _____

Address: _____
Street

_____,_____,_____
City State ZIP

I certify that the following rate, $_____ per day, has been negotiated for the above-named child for Medicaid reimbursable Residential Treatment.

The Medicaid rate noted above should reflect the negotiated rate minus expected reimbursement from all other payment sources, such as Title IV-E. The total of the reimbursement from all other sources cannot exceed the Medicaid maximum rate for this service. This rate shall be effective for dates of service beginning on _____/____/_____
Month Day Year*

CPMT Signature: _____

Print Name: _____

Title: _____

Date: _____

*Date must be current year.

DMAS 600 4/07

Example form for DMAS purposes only. *This example was developed to indicate the minimum information required and is not expected to meet licensing or other third-party payer requirements.*